I '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED 02/24/2011			
		155579	B. WIN	UII				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
   MILLER'S	S MERRY MANOR		7440 N 825 E HOPE, IN47246					
(X4) ID		TATEMENT OF DEFICIENCIES		ID ID	1117210		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE	
F0000	This visit was	for a Recertification	F00	00	We respectfully request paper			
10000		nsure Survey. This	100	00	compliance for this Plan of			
		· ·			Correction.			
		the Investigation of						
	Complaint IN(	00085803.						
		00005000						
	Complaint IN(							
		No deficiencies						
	related to the a	allegations are cited.						
	Survey dates: February 21, 22, 23, and 24, 2011							
	Facility number	er: 000286						
	Provider numb	per: 155579						
	AIM number: 100291000							
	Survey team:							
	Diana Sidell R	en TC						
	Penny Marlatt							
	Sharon Whiter							
	Sharon white	man Kin						
	Conque had to	no:						
	Census bed ty	pe.						
	SNF/NF: 68							
	Total: 68							
	Census payor type:							
	Medicare: 12							
	Medicaid: 46							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GVL811

Facility ID:

000286

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/G AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
155579		A. BUILDING	COMPLETED 02/24/2011			
		100070	B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/24/2011	
NAME OF F	PROVIDER OR SUPPLIER		l l	825 E		
	S MERRY MANOR		HOPE,	IN47246		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
-	Other: 10	<u> </u>				
	Total: 68					
	101. 00					
	Sample: 15					
	Supplemental	sample: 2				
	Supplemental	Sumple. 2				
	This deficience	y also reflects state				
		cordance with 410				
	IAC 16.2.					
	110 10.2.					
	Onality review	completed 3/1/11 by				
	Jennie Bartelt,	_				
	Jennie Barten,	IXIV.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155579		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/24/2011			
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 7440 N 825 E HOPE, IN47246				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
F0332 SS=D	review, and in failed to ensur than 5% during observation. To 4 medication a total of 43 medication and error rate deficient practice residents observed medications during inclusions of the control of	de:  I at 4:10 p.m., RN #1  to administer Resident #46. Received 40 Furosemide (diuretic 0 milligrams of od pressure ad (2) 325 milligrams edication used to	F03	32	We respectfully request paper compliance for this Plan of Correction. This facility will ensure that it is free from a medication error rate great than 5%. Resident #46 was affected by this deficient practice. The attending physician was promptly notified. Resident was monitored for 24 hours with change in vital signs or condition noted. Family was also promptly notified. Medication orders have been clarified and are being administered as directed. Resident #23 ws affected by this deficient practice. The attending physician and fam were notified promptly of the medication error. Resident we monitored for 24 hours. No adverse event or change in vital signs or condition was noted. RN#1 will be disciplin progressively or terminated further violations. Date of completion 3/26/11. All residents could be affected by this deficient practice. Every nurse will be educated on medication administration basics and audited for performance See Attachme A and B. This medication administration in service and audit will be completed by 3/26/11. All newly hired nurs are trained as part of their	no illy vas	03/26/2011

AND PLAN OF CORRECTION IDI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED
		155579	B. WIN	IG		02/24/2011
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR				7440 N	ADDRESS, CITY, STATE, ZIP CODE 825 E IN47246	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  record on 02/22/11 at 4:40 p.m.		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  orientation process. This	(X5) COMPLETION DATE		
	An admission dated 02/14/11 #46 was to recomilligrams ever and Tylenol 50 hours as needed order did not in Tylenol 650 m there an order  Interview of U 02/22/11 at 4:4 pharmacy had wrong "roll of and today was been given." U indicated Residan order for Fu incorrect dosaggiven.  Review of a "Marting for February 2 Lisinopril 10 m."	physician's order, I, indicated Resident eive Lisinopril 10 ery day at 6:00 a.m. 00 milligrams every 6 ed. The physician's nclude an order for nilligrams, nor was for Furosemide.  Init Manager #2 on 15 p.m., indicated the probably sent the meds (medications) the first day they had Unit Manager #2 dent #46 did not have arosemide and the ge of Lisinopril was			process will be monitored by doing annual and as needed nursing skills review of Medication Pass Observation Any errors or improper procedure will have immediate-education. The DON or designee will do the Medicate Pass Audits for 10% of residents bi-weekly for 4 weeks, monthly for 2 months and quarterly thereafter. See Attachment c. The Medication Audit results will be reviewed by the Quality Assurance Committee and any recommendations by the Committee will be followed.	n. ite ion

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	SUPPLIER/CLIA (X2) M		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BU		LDING		COMPLETED	
155579		155579	B. WIN			02/24/2011	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
			7440 N 825 E				
MILLERS	S MERRY MANOR			HOPE,	IN47246		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	THE APPROPRIATE	
1710		nol 500 milligrams	+	1710	·		DATE
		•					
	_	n to Resident #46					
	1 1	as needed. The					
	"Medication R						
		n supporting the					
	resident was to	receive Furosemide.					
	2. On 02/22/1	1 at 4:20 p.m., RN					
	#1 was observ	ed to administer 1					
	and ½ capsules of Tylenol 325 milligrams to Resident #23.						
	minigrams to resident #25.						
	Review of Res	sident #23's clinical					
		22/11 at 4:45 p.m.,					
	indicated the f	•					
	marcated the r	onowing.					
	   Resident #23 1	nad a physician's					
		uary 2011 which					
		•					
		der, dated 07/14/10,					
	for Tylenol 500 milligrams as						
		1 ½ capsules (750)					
	milligrams at bedtime as needed for pain. The physician's order did not include an order for Tylenol for the dose that was observed being given.						
	A medication	administration record					
	(MAR) for Fel	bruary 2011 indicated					
		•					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155579		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/24/2011			
NAME OF PROVIDER OR SUPPLIER			B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	l		
MILLER'S MERRY MANOR			7440 N 825 E HOPE, IN47246					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					TE	COMPLETION DATE	
	Resident #23 v						21112	
	Tylenol 500 m	nilligrams - give 1 ½						
	capsules (750)	milligrams at						
		eded for pain. The						
		include an order for						
	Tylenol 325 m	nilligrams.						
	3.1-25(b)(9)							
	3.1-(c)(1)							